

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot
City or town Hillsboro Ind. Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Talbot
City or town Hillsboro Ind. Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Blus Wesley Berry

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Anna Jean Berry

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Dec. 2nd 1892

8. AGE: Years 73 Months 8 Days 32 If less than one day _____ hrs. _____ min.

9. Birthplace New Hillsboro Ind.
(Town, county, and state)

10. Usual occupation Day Laborer

11. Industry or business Home

12. Name Bateman Berry

13. Birthplace unrecorded

14. Maiden name Sophie Wright

15. Birthplace Maryland

16. Informant Anna Berry (wife)

Address Hillsboro Ind.

17. Buried Date thereof Sept. 1, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Sandtown

Location Hillsboro Ind.

18. Funeral director W. J. Vigil

Address Denton Ind.

19. 8/28 1946 N. H. Deery
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1946, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27 1946, to August 28 1946, and that I last saw him alive on July 4 1946

Immediate cause of death Anterior cross of aorta
of brain

Due to Generalized arterioscl.
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE W. J. Vigil M. D. or other _____

Address W. J. Vigil Date signed 8/29

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 4 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1250

08328

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County... Talbot
 City or town... Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred:
The Memorial Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... Maryland County... Caroline
 City or town... Denton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. American Green
 (If rural, give LOCATION)
 2.(a) If veteran, name war... ☒

3. (a) FULL NAME

Mrs. Maggie Brown

3. (b) Social Security Number

4. Sex F 5. Color of hair W 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Mr. Jacob Brown
 7. Birth date of deceased (mo., day, yr.) Feb. 17 1886 6. (c) If alive, give age 66 years
 8. AGE: Years 60 Months 6 Days 5 If less than one day hrs. min.

9. Birthplace East New Market Md.
 (Town, county, and state)

10. Usual occupation H. Work

11. Industry or business Home

FATHER 12. Name Ben. T. Wheatley

13. Birthplace East New Markt. Md.

MOTHER 14. Maiden name Margie Shuler

15. Birthplace Virginia

16. Informant Jacob W. Brown

Address Denton, Maryland, R.F.D.

17. Burial Date thereof August 24 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory East New Market Cemetery

Location East New Market, Maryland

18. Funeral director J. J. Fraughton and Son

Address Federalburg, Maryland

19. 8/23 19 46 N. S. Neerue
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22/46 19 46 at 4:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/20 19 46 to 8/22 19 46
 and that I last saw E.R. alive on 8/22 19 46

Immediate cause of death acute yellow atrophy of liver
 DUE TO 7 weeks DURATION 10 days

Other conditions cholecyctis, etc. DURATION 10 days
 (Include pregnancy within 3 months of death)

Major findings of operations no op Date of op. no op
 Autopsy results acute yellow atrophy of liver
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of no op
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury injured at work?

23. SIGNATURE Wm. H. Noble M. D. or other
 Address Easton Md. Date signed 8/23/46

RECEIVED

SEP 4 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (454)

CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:

County... **Talbot**
 City or town... **St. Michaels**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **35 years**
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... **Maryland** County... **Talbot**
 City or town... **St. Michaels**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. (If rural, give LOCATION)
 2.(a) If veteran, name war **World War I**

3. (a) FULL NAME

Perry A. Cephas

3. (b) Social Security Number

217-07-3176

4. Sex **Male** 5. Color or race **Colored** 6.(a) Single, married, widowed, or divorced **Married**
 6.(b) Name of husband or wife
 6.(c) If alive, give age **45** years
 7. Birth date of deceased (mo., day, yr.) **February 26 1890**
 8. AGE: Years **56** Months **5** Days **22** If less than one day
 hrs. min.

9. Birthplace **Trappe Talbot Co. Maryland**
 (Town, county, and state)

10. Usual occupation **Laborer**

11. Industry or business

FATHER 12. Name **Perry Cephas**
 13. Birthplace **Trappe Maryland**

MOTHER 14. Maiden name **Mary Mathon**
 15. Birthplace **Trappe Maryland**

16. Informant **Emma Portlock**
 Address **2229 Ellsworth St/ Phila. Pa.**

17. Burial Date thereof **8-19046**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory **Claiborne Colored**
 Location **Claiborne, Maryland**

18. Funeral director **J. Norman Marshall**
 Address **St. Michaels, Maryland.**

19. **Aug 19 1946** John H. Stewards
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **Aug. 16 1946** at **5 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Sept. 5 1945** to **Aug. 16 1946**

and that I last saw him alive on **Aug. 16 1946**

Immediate cause of death **Carcinoma of Stomach**

DURATION **14 mo.**

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Hayward T. 1/24 M.D.**

Address **Expton, Md.** Date signed **8/17/46**

RECEIVED
AUG 27 1946
BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore Md.

CERTIFICATE OF DEATH

 18330 290
 Reg. Dist. No.

1. PLACE OF DEATH: County <u>Talbot</u> City or town <u>Boston</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>35 Years</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?					2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Talbot</u> City or town <u>Boston</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>P.O. # 7</u> (If rural, give LOCATION) 2.(a) If veteran, name war				
3. (a) FULL NAME <u>Margaret Elizabeth Cooper</u>					3. (b) Social Security Number				
4. Sex <u>Female</u>		5. Color or race <u>Colored</u>		6. (a) Single, married, widowed, or divorced <u>Widow</u>					
6. (b) Name of husband or wife <u>J. Thos. Cooper</u>									
7. Birth date of deceased (mo., day, yr.) <u>Sept. 1, 1861</u>									
8. AGE: Years <u>84</u>		Month <u>11</u>		Days <u>19</u>		If less than one day _____ hrs. _____ min.			
9. Birthplace <u>Talbot Co. Md.</u> (Town, county, and state)									
10. Usual occupation <u>Housewife</u>									
11. Industry or business <u>At Home</u>									
FATHER	12. Name <u>Thomas Henry Jones</u>								
	13. Birthplace <u>Maryland</u>								
MOTHER	14. Maiden name <u>Posetta McNamee</u>								
	15. Birthplace <u>Maryland</u>								
16. Informant <u>John Cooper</u> Address <u>Boston, Md.</u>									
17. (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>Aug. 24 1946</u> (month) (day) (year) Cemetery or crematory <u>Williamstown</u> Location <u>Boston, Md.</u>									
18. Funeral director <u>J. Ellis Clark</u> Address <u>Boston, Md.</u>									
19. <u>8/23</u> 19 <u>46</u> <u>N. H. Neer</u> (Date rec'd by registrar) Registrar									
MEDICAL CERTIFICATION									
20. DATE OF DEATH <u>August 20</u> 19 <u>46</u> , at <u>6 P.</u> M									
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>Sept. 6</u> 19 <u>46</u> , to <u>Aug. 20</u> 19 <u>46</u> and that I last saw him/her alive on <u>Aug. 20</u> 19 <u>46</u>									
Immediate cause of death <u>Chronic Endocarditis</u>								DURATION <u>2</u>	
Due to _____									
Due to _____									
Other conditions _____									
(Include pregnancy within 3 months of death)									
Major findings of operations _____ Date of op. _____									
Autopsy results _____									
PHYSICIAN: Please underline the cause to which death should be charged statistically.									
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) (County) (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____									
23. SIGNATURE <u>Hayward T. Webb MD</u> <u>Boston, Md.</u> M. D. or other _____ Date signed <u>Aug 22/46</u>									

RECEIVED

SEP 4 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08331

Reg. Dist. No. 290

1. PLACE OF DEATH:

County... Talbot
 City or town... Easton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 hours 4 min.
 Hospital, institution, or street address where death occurred:
The Memorial Hospital Easton
 How long in hospital or institution? 8 hours 4 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Talbot
 City or town... Tilghman
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war...

3. (a) FULL NAME

Albert Avery
Baby Boy Cummings
 4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced

3. (b) Social Security Number

(Newborn Premature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/19/46 19... at 1:29 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
8-18-1946 to 8-19-1946
 and that I last saw him alive on 8-18-1946

Immediate cause of death

DURATION

Prematurity (wt 2 lbs 7 oz) 7 months
 Due to Placenta Previa
 Due to
 Other conditions membrane ruptured
two months ago
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Easton Md. Date signed 8-20-46

11. Industry or business

12. Name McLaurie Cummings
 13. Birthplace Tilghman Md.
 14. Maiden name Miss Doris Chuzum
 15. Birthplace Preston Md.
 16. Informant Mrs. Alice Cummings
 Address Tilghman Md.
 17. Burial Date thereof 8/20/46
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Tilghman
 Location Tilghman Md.
 18. Funeral director J. J. Marshall
 Address W. D. Marshall
 19. 8/19 19 46 N. H. Jones
 (Date rec'd by registrar) Registrar

RECEIVED
AUG 24 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

08332

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:
County... TALBOT
City or town... Cardova Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Md County... Talbot
City or town... Cardova
(If outside city or town limits, write RURAL and give nearest town)
Street No...
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME
JAMES DAYENPOYT

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr) April 11, 1856 6. (c) If alive, give age years

8. AGE: Years 90 Months 3 Days 28 It less than one day hrs. min.

9. Birthplace Talbot Co. Md
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name James Dayenpoyt
13. Birthplace Talbot Co. Md

14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Earl W. Stefford
Address Easton Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Aug. 9/46
(month) (day) (year)
Cemetery or crematory Spring Hill Cemetery
Location Easton Talbot Co. Md.

18. Funeral director Earl W. Stefford
Address Easton Md.

19. (Date rec'd by registrar) 8/9 19 46 N. H. Nevers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7 19 46 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/8/46 to 8/7/46 and that I last saw him alive on 7/12/46

Immediate cause of death Chronic myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

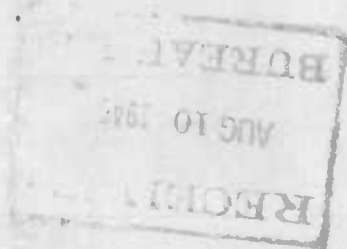
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE N. H. Nevers M. D. or other

Address Easton Md. Date signed 8-8-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
of deceased is shown on

2411 N. Charles St., Baltimore

08333

Reg. Dist. No. 290

FILM No. I O 6 AUG 26 1946

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Salisbury
City or town Easton, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 49 days
Hospital, institution, or street address where death occurred:
The Memorial Hospital, Easton, Md.
How long in hospital or institution? 49 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Salisbury
City or town Easton
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Mr. Thomas Dill

3. (b) Social Security Number

4. Sex M. 5. Color or race W 6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife _____
7. Birth date of deceased (mo., day, yr.) Oct. 14, 1885 6. (c) If alive, give age _____ years
8. AGE: Years 64 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business _____

FATHER 12. Name W. C. Dill
13. Birthplace Ohio
MOTHER 14. Maiden name Lizzie Green
15. Birthplace Delaware

16. Informant Earl W. Stafford
Address Easton Md.

17. Burial Date thereof 8/13/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematorium Spring Hill
Location Easton Md.

18. Funeral director Earl W. Stafford
Address Easton Md.

19. 8/12/46 19 46 N. H. Harris
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH August 8 19 46 at 8:29 p.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 25 19 46 to August 8 19 46
and that I last saw him alive on Aug 8 19 46

Immediate cause of death Cancer of Stomach DURATION unknown

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations advanced adenocarcinoma of stomach Date of op. 7/13/46

Autopsy results not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. T. B. Ambler M.D. M. D. or other _____

Address Easton, Md. Date signed 8/10/46

RECEIVED
AUG 19 1946
BUREAU V.8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

 ★ 8334
 Reg. Dist. No. 290

1. PLACE OF DEATH:

County Ticket
 City or town Rural Cordova
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Ticket
 City or town Rural Cordova
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Philip Ann Fike

3. (b) Social Security Number

4. Sex

F

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

S.

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

April 11, 1943

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

3327

hrs.

min.

9. Birthplace

Ridgely, Caroline, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Paul Fike

13. Birthplace

MD

MOTHER

14. Maiden name

Ellen May Furey

15. Birthplace

MD

16. Informant

Address

Paul Fike
Cordova, P. D. Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Aug 10, 1946
(month) (day) (year)

Cemetery or crematory

Burial

Location

Cordova, MD

18. Funeral director

Address

Walter Bank
Cordova, MD

19.

8/19
(Date rec'd by registrar)19. 46N. H. Neville
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 19 46 at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 28 19 46 to August 11 19 46
and that I last saw her alive on August 16 19 46

Immediate cause of death

Chronic lymphatic leukemia

DURATION

more than 3 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Walter Bank
M. D. or otherAddress U.S. Army Hospital Date signed 8/19

RECEIVED

AUG 24 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

CERTIFICATE OF DEATH

08335

Reg. Dist. No. 291

1. PLACE OF DEATH:

County TalbotCity or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town St. Michaels
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Samuel M. Gates

3. (b) Social Security Number

217-03-61114. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Blanche Gates

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 30, 18828. AGE: Years 64 Months 4 Days 22 If less than one day _____ hrs. _____ min.9. Birthplace Talbot County
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name John Gates13. Birthplace Talbot County14. Maiden name Henrietta Thomas15. Birthplace Talbot County16. Informant Blanche GatesAddress St. Michaels, Md.17. Burial Burial Date thereof Aug. 21, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory CemeteryLocation St. Michaels, Md.18. Funeral director J. Norman MarshallAddress St. Michaels, Md.19. Aug 19 19 46 John J. Swales
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 August 19 46 at 0415AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 Aug 19 46 to 18 August 19 46and that I last saw him alive on 11 August 19 46Immediate cause of death Chronic Nephritis DURATION unknownDue to Unhealed perineal prostatectomy 5 years

Due to _____

Other conditions Left hemiplegia

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. Herbert Morrison M.D. M. D. or other _____Address St. Michaels, Md. Date signed 19 Aug 46

RECEIVED

AUG 27 1946

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7400

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot
 City or town Easton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 days
 Hospital, institution, or street address where death occurred:
The Memorial Hospital Easton, Md.
 How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot
 City or town Offord
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

Mr. Edward Haddaway

3.(b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced +

B.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 23 1862 6.(c) If alive, give age _____ years

8. AGE: Years 84 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Offord, Md.
 (Town, county, and state)

10. Usual occupation Weekman

11. Industry or business

12. Name William H. Haddaway13. Birthplace Tilghman14. Maiden name Jessie Gibson15. Birthplace Tilghman18. Informant Earl W. StaffordAddress Easton, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof 8/14/86
 (month) (day) (year)

Cemetery or crematory OffordLocation Offord, Md.18. Funeral director E. W. StaffordAddress 307 Goldboro St. Easton.

19. 8/12 19 46 N. B. Neese
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11 19 46 at 6:52 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 6 19 46 to August 11 19 46
 and that I last saw him alive on August 11 19 46

Immediate cause of death Coronary thrombosis

DURATION

Due to arterio sclerosis ?

Due to _____

Other conditions Pneumonia, aneurysm ?

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Norman Hamilton M.D.

M. D. or other

Address Easton Date signed 11 Aug 86

RECEIVED
AUG 19 1945
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 482

CERTIFICATE OF DEATH

08337

Reg. Dist. No. 290

1. PLACE OF DEATH:

County... TalbotCity or town... Easton Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 57 days

Hospital, institution, or street address where death occurred:

The Memorial HospitalHow long in hospital or institution? 57 days

3. (a) FULL NAME

Mrs. Gladys Harrison4. Sex F. 5. Color or race W. 6. (a) Single, (married), widowed, or divorced6. (b) Name of husband Mr. Raymond L. Harrison7. Birth date of deceased (mo., day, yr.) Dec. 16, 18828. AGE: Years 63 Months 7 Days 23 If less than one day
.....hrs.min.9. Birthplace... Talbot Co.
(Town, county, and state)10. Usual occupation... H. W.

11. Industry or business

12. Name... James C. Lomas13. Birthplace... Md.14. Maiden name... Lacie Warner15. Birthplace... Md.16. Informant... Raymond HarrisonAddress... Easton Md.17. (Burial, cremation, or removal, Which?) Buried Date thereof 8/11/46
(month) (day) (year)Cemetery or crematory... ShenwoodLocation... Shenwood18. Funeral director... R. Ellis Clark, Inc.Address... Easton, Md.19. 8/10 19 46 M. H. Neerer
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... TalbotCity or town... Easton
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... 8/9/46 19... at 2:15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 July 19... to 9 Aug 19...
and that I last saw him alive on 8 Aug 19...
Immediate cause of death... Brain abscess, pneumonia & generalized carcinoma of breastDue to... Breast cancer of the cervix DURATION 1 1/2 yrs

Due to... ..

Other conditions... ..

(Include pregnancy within 3 months of death)

Major findings of operations... ..

Date of op.

Autopsy results... ..

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... .. Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE... Raymond Harrison M.D.Address... Easton Date signed... 10 Aug 46

RECEIVED

AUG 19 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH

County... TalbotCity or town... Easton, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Memorial HospitalHow long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... CarolineCity or town... Pidgey
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mildred Henry

3. (b) Social Security Number

4. Sex

F

5. Color or race

B

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Edward Henry

7. Birth date of

deceased (mo., day, yr.)

Jan. 30, 18966. (c) If alive, give age 49 years

8. AGE:

Years

Months

Days

If less than one day

50

.....hrs.min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

H. W.

11. Industry or business

FATHER

12. Name

Eugene Groce

13. Birthplace

Md.

14. Maiden name

Frances Lawrence

15. Birthplace

Md.

16. Informant

Edward Henry

Address

Pidgey, Md.

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

8/54619461946194619461946

23. SIGNATURE

Address

Easton Md.

Date signed

8-8-46

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/4/46 19... at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-17-

19... to

8-4-

19... 46

and that I last saw him alive on

8-1-

19... 46

Immediate cause of death

Sepsis

Due to

cellulitis, left hand

Due to

Other conditions

Diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Easton Md.

Date signed

8-8-46

DURATION

1 month1 month?

REC'D

AUG 10 1941

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 166

CERTIFICATE OF DEATH

08339
Reg. Dist. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 30 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Federalburg
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

James E. Hill

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Olevia Hill6. (c) If alive, give age 35 years

7. Birth date of

deceased (mo., day, yr.)

February 10, 1910

8. AGE:

Years

36

Months

6

Days

3

If less than one day

hrs. min.

9. Birthplace

Sussex County, Delaware
(Town, county, and state)

10. Usual occupation

Day laborer

11. Industry or business

Truck Driver

FATHER

12. Name

Walter Hill

13. Birthplace

Pianna, Maryland

MOTHER

14. Maiden name

Helen Nichols

15. Birthplace

Sussex County, Delaware

16. Informant

Mrs. Helen Hill

Address

Seaford, Delaware

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

August 16, 1946
(month) (day) (year)

Cemetery or crematory

Bethel Cemetery

Location

Near Federalburg, Maryland

18. Funeral director

F. J. Frampton and Son

Address

Federalburg, Maryland

19.

(Date rec'd by registrar)

8/161946M. H. Neerius
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1946, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death

Gunshot wound left chest

DURATION

17 hours

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

homicide

Date of

8-13-46

Where did injury occur?

Federalburg
(City or town)Caroline
(County)md
(State)

Injured at home, farm, industry, public place (where?)

public place

Means of injury

BSW. pistol

Injured at work?

no

23. SIGNATURE

Louis J. Shetty, MD
Easton, MD

M. D. or other

Address

Date signed

8-14-46

RECEIVED
AUG 19 1946
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46-2

08340

CERTIFICATE OF DEATH

Reg. Dist. No. 491

1. PLACE OF DEATH:

County Talbot
 City or town St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ind County Talbot
 City or town St. Michaels
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war none

3. (a) FULL NAME

Dr. James H. Hope

3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Eleanor Radcliffe Hope

7. Birth date of deceased (mo., day, yr.) Oct 18 1882 6. (c) If alive, give age _____ years

8. AGE: Years 63 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace St. Michaels, Talbot Co. Ind.
 (Town, county, and state)

10. Usual occupation Physician

11. Industry or business _____

12. Name Daniel W. Hope

13. Birthplace St. Michaels, Ind

14. Maiden name Eleanor Ball

15. Birthplace St. Michaels Ind

16. Informant Mrs. J. H. Hope

Address St. Michaels Ind.

17. Burial Date thereof Aug 31 1946
 (Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Christ Cemetery

Location St. Michaels, Ind

18. Funeral director Newnam & Harrison

Address St. Michaels Ind.

19. Aug 27 19 46 John Howes
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 19 46, at 12 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 19 46, to Aug 28 19 46.

and that I last saw him alive on Aug 28 19 46

Immediate cause of death exhaustion DURATION _____

insanitation

Due to Intestinal obstruction

Due to Papillomatosis of colon

Other conditions _____

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

RECEIVED

SEP 5 1946

BUREAU OF VITALS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B3-2

CERTIFICATE OF DEATH

Reg. Dist. No. 0834 290

1. PLACE OF DEATH

County Talbot
 City or town Royal Oak
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 month
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State md. County Talbot
 City or town Royal Oak
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

George Jester

3. (b) Social Security Number

220-12-0383

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Ruth Lee Jester

6. (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Dec. 25/1902

8. AGE: Years 43 Months 8 Days - If less than one day _____ hrs. _____ min.

9. Birthplace Greenville, Va.
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business _____

12. Name Isaac Jester

13. Birthplace Greenville Md.

14. Maiden name Mamie Anderson

15. Birthplace Greenville Md.

16. Informant Ruth Lee Jester

Address Easton RD #4- Md.

17. Burial Fuller Hill Cemetery

Date thereof Aug 29 46
 (Month) (day) (year)

Cemetery or crematory Fuller Hill Cemetery

Location Greenville, Md.

18. Funeral director John E. Williams

Address Easton, Md.

19. 8/28 19 46 N.H. Morris

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25th 19 46, at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 4 19 46 to Aug. 25 19 46 and that I last saw him alive on Aug. 25th 19 46

Immediate cause of death Pylephlebitis Oculitis DURATION 4 weeks

Due to _____

Due to _____

Due to _____

Other conditions acute Paratyphoid fever DURATION 2 to 3 months

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Samuel T. Webb M. D. or other _____

Address Easton, Md. Date signed 8/28/46

RECEIVED

SEP 4 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08342 291

1. PLACE OF DEATH:

County..... Talbot
 City or town..... Royal Oak
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Talbot
 City or town..... Royal Oak
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Lloyd Washington Limberry

3. (b) Social Security Number

215-26-4329

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Mary Emma Limberry

7. Birth date of

deceased (mo., day, yr.)

March 28th 1878

6.(c) If alive, give age

34 years

8. AGE:

Years

Months

Days

If less than one day

68

4

12

hrs.

min.

9. Birthplace

Royal Oak, Talbot Maryland

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Packing houses

FATHER

12. Name

Horace Limberry

13. Birthplace

Royal Oak Talbot Maryland

MOTHER

14. Maiden name

Unknown

15. Birthplace

16. Informant

Mary Emma Limberry

Address

Royal Oak, Maryland

17.

Burial

Date thereof

8-10-46

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Royal Oak Colored

Location

Royal Oak, Maryland

18. Funeral director

J. N. Marshall

Address

St. Michaels, Maryland

19.

8/9
(Date rec'd by registrar)

19.

46 John H W Wake
Incl Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 8

19

46, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1946

to

Aug. 8 1946

and that I last saw him alive on

Aug. 8 1946

Immediate cause of death

Chronic endocarditis

DURATION

1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Hayward T. Bell, M.D.

M. D. or other

Address

Baltimore, Md. Date signed 8/9/46

RECEIVED

AUG 19 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B7D)

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Easton, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital, Easton, Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen AnneCity or town Queenstown
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name War _____

3. (a) FULL NAME

Benjamin Melvin

3. (b) Social Security Number

none

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M.

6. (b) Name of husband or wife

Mrs Anna Edith Melvin7. Birth date of deceased (mo., day, yr.) March 10, 18688. (c) If alive, give age 64 years

8. AGE:

Years

Months

Days

If less than one day

78

hrs.

min.

9. Birthplace

Pocomoke Island, Dorchester Co, Md
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER
MOTHER

12. Name

Samuel Melvin

13. Birthplace

Queen Anne Co, Md

14. Maiden name

Fredy Allen

15. Birthplace

Queen Anne Co, Md

16. Informant

Mrs Anna Edith Melvin

Address

Queenstown, Md

17.

Buried
(Burial, cremation, or removal. Which?)

Date thereof

Aug 16-46
(month) (day) (year)

Cemetery or crematory

Christiansburg

Location

Centerville, Md

18. Funeral director

Tracy Bros

Address

Centerville, Md

19.

8/16
(Date rec'd by registrar)

19.

46N.H. Pearson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 14 19 46, at 7:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 6 19 46, to Aug 14 19 46and that I last saw him alive on Aug 4 19 46

Immediate cause of death

Arteriosclerosis, Generalized

DURATION

?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Hypertrophied Prostate, Benign Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury

Injured at work?

23. SIGNATURE

N.H. Pearson M.D.

M. D. or other

Address Easton, Md Date signed 8/15/46

RECEIVED
AUG 19 1946
BUREAU V 8

Reg. Dist. No. 290

Franklin 15d 9th Nov 9

RECEIVED
AUG 10 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: Talbot Co. Md.
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 da.
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 8 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
or newborn infants give residence of mother)
State: Maryland County: Talbot
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)

3. (a) FULL NAME

Louise Pardoe

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6. (b) Name of husband or wife: Lester Pardoe
7. Birth date of deceased (mo., day, yr.): June 28, 1917
8. AGE: Years: 29 Months: 1 Days: 30 It less than one day: hrs. min.

9. Birthplace: Talbot Co. Md.
(Town, county, and state)
10. Usual occupation: H.W.

11. Industry or business

FATHER
12. Name: Samuel Ballard
13. Birthplace: Talbot Co. Md.
MOTHER
14. Maiden name: Lottie Willey
15. Birthplace: Talbot Co. Md.

16. Informant: Lester Pardoe
Address: Easton Md.

17. (Burial, cremation, or removal. Which?) Date thereof: Aug 29, 46
(month) (day) (year)

Cemetery or crematory: Spring Hill
Location: Easton Md.

18. Funeral director: William H. Murren
Address: Easton Md.

19. 8/28 1946 N.B. Neirin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 27 1946 at 10:55 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 21, 1946, to Aug. 27, 1946, and that I last saw him alive on Aug. 27, 1946.

Immediate cause of death: Metastatic Carcinoma of Liver
Due to: Carcinoma of Cervix
Due to: Carcinoma of Cervix

Other conditions

(Include pregnancy within 3 months of death)
Major findings of operations: Uterus in situ
Date of op. 8-1-46

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Martin F. Buell M.D.
Address: 17 Goldsboro St. E. Date signed: 8-28-46

RECEIVED

SEP 4 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

08346

Reg. Dist. No. 290

1. PLACE OF DEATH:

County... Sabot
City or town... Oxford, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Sabot
City or town... Oxford, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No...
(If rural, give LOCATION)
2.(a) If veteran, name war...

3. (a) FULL NAME

Mary Isabel Pinder
Baby Girl Pinder

3. (b) Social Security Number

4. Sex F 5. Color or race # Col. 6.(a) Single, married, widowed, or divorced Single

8.(b) Name of husband or wife Walter Irene Pinder

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1946 6.(c) If alive, give age... years

8. AGE: Years Months Days If less than one day
2 1/2 hrs. min.

9. Birthplace... Eastern Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Nicholas Pinder
13. Birthplace Talbot Co. Md.

14. Maiden name Irene M. Williams
15. Birthplace Va.

16. Informant Ida H. Brooks
Address Eastern Md.

17. Burial, cremation, or removal, Which? Burial Date thereof 8/16/46
(month) (day) (year)
Cemetery or crematory Oxford Week
Location Oxford Md.

18. Funeral director Nicholas Pinder
Address Oxford Md.

19. 8/16 1946 N.H. Neer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1946 at 1:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15, 1946 to Aug 15, 1946
and that I last saw him alive on Aug 15, 1946

Immediate cause of death Prnaturity (7mo)

Due to...

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis P. Kelly, M.D.
M. D. or other
Address Oxford Md. Date signed 8-16-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 24 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57)

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County TalbotCity or town Queen Anne, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 16 days

Hospital, institution, or street address where death occurred.

How long in hospital or institution?

3. (a) FULL NAME

Benjamin Price

4. Sex

male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 30, 1946

B. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

16

hrs.

min.

9. Birthplace Queen Anne, Talbot, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Walter Price

13. Birthplace

Tennessee

MOTHER

14. Maiden name

Helen Louise Pinkney

15. Birthplace

Queen Anne, Md.

16. Informant

Reggie Pinkney

Address

Queen Anne, Md.

17.

Bemoral

Date thereof

8/15/46

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Hillsboro

Location

Hillsboro, Md.

16. Funeral director

Walter Price

Address

Queen Anne, Md.

19.

8/15

19.

46Dr. D. Neenan

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Queen Anne
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 19 46, at 2:17 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 19 46, to August 14 19 46, and that I last saw him alive on August 14 19 46.

Immediate cause of death

Prematurity

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Kurt Leberer M.D.

M. D. or other

Address Queen Anne, Md. Date signed 8/14

7-1-0

RECEIVED
AUG 19 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Morrison
08348

Reg. Dist. No. 291

1. PLACE OF DEATH

County Fallot
City or town St. Michael
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Fallot
City or town St. Michael
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Felda Morrell Ruffledge

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Margaret Weil
6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) May 20 - 1891 -

8. AGE: Years 55 Months 2 Days 21 hrs. _____ min. _____

9. Birthplace Cleveland, Ohio
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Turkey Farmer

12. Name George P. Ruffledge

13. Birthplace Canada

14. Maiden name Farritt Warden

15. Birthplace Cleveland, Ohio

16. Informant Margaret Ruffledge

Address St. Michael, Md.

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof Aug 12, 1946
(month, day, year)

Cemetery or crematory Rosedale Cemetery

Location Mountclair, Md. County

18. Funeral director John D. Mulligan

Address Exton, Md.

19. 8/11 19 46 D. H. Nevins
(Date recd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10th 19 46 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 April 19 46 to 10 August 19 46
and that I last saw him alive on 9 August 19 46

Immediate cause of death Cerebral Embolus

Due to Heart Disease

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide none Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. Herbert Morrison

Address St. Michael, Md. Date signed 11 Aug. '46

MARGIN RESERVED FOR BINDING

I

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 19 1945
BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 125-L

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot Co
City or town Wye Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all his life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Talbot
City or town Wye Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war World War # 1

3. (a) FULL NAME

Erwin Hackett Sewell

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Lella Callahan Sewell
6.(c) If alive, give age 43 years
7. Birth date of deceased (mo., day, yr.) June 6 - 1895
8. AGE: Years 51 Months 2 Days 11 If less than one day
hrs. min.

9. Birthplace Wye Mills, Queen Anne's Co. Md
(Town, county, and state)

10. Usual occupation Merchant

11. Industry or business General Store

12. Name John S. Sewell

13. Birthplace Delaware

14. Maiden name Wilmiea Stanley

15. Birthplace Queen Anne's Co. Md

16. Informant Howard W. Sewell

Address Queen Anne, Maryland.

17. Burial Date thereof Aug 19-46
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Chestertown

Location Centerville Maryland

Barton Brook

18. Funeral director Centerville Maryland.

Address N. H. Nevers

19. 8/19 19 46
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 19 46 at 8:25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 11 19 46 to Aug 17 19 46

and that I last saw him alive on Aug 17 19 46

Immediate cause of death Acute Hepatitis

Due to

Due to

Other conditions Coronary dilatation

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. Henry Fisher

Address Centerville Md

Date signed 8/17-46

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RI
AUG 24 1946
BUREAU V C

Evidence for change of
place of death is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 166

CERTIFICATE OF DEATH

Reg. Dist. No. 290

FILM No. 106 AUG 23 1946

1. PLACE OF DEATH:

County Stafford
City or town Easton Rural Chapel Sta. Cannery
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Va. County Suffolk
City or town Suffolk
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Roywell Smallwood

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Dorothy Morgan6.(c) If alive, give age 24 years7. Birth date of
deceased (mo., day, yr.) 19248. AGE: Years 35 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Suffolk, Va.
(Town, county, and state)10. Usual occupation Laborer11. Industry or business Canning Factory12. Name Roywell Smallwood13. Birthplace Suffolk, Va.14. Maiden name Harlebe Smallwood15. Birthplace Suffolk, Va.16. Informant Dorothy SmallwoodAddress 277 Star St Norfolk Va.17. Rural Date thereof Aug 15 1946
(Burial, cremation, or other) (month) (year)Cemetery or crematorium Richards CemeteryLocation Easton, Md.18. Funeral director John D. WilliamsAddress Easton Md.19. 8/14 19 46 N. D. Newman
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11th 19 46 at 3:35 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____ to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death

Multiple perforations abd.Due to VisceraDue to B.S.W. (shotgun)

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings at operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide homicide Date of 8-11-46Where did injury occur? in Easton (City or town) (County) (State)Injured at home, farm, industry, public place (where?) homeMeans of injury B.S.W. Injured at work? No23. SIGNATURE Louis M. M. M. D. or otherAddress Easton Md. Date signed 8/14/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 19 1946
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(157)

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Salisbury CountyCity or town Easton, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address, where death occurred:

Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SalisburyCity or town Easton
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

3. (b) Social Security Number

Smullen4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Inf.6. (b) Name of husband or wife Mrs. Leta SmullenCity or town Easton, Maryland 6. (c) If alive, give age 16 years7. Birth date of deceased (mo., day, yr.) Aug. 8, 1946

8. AGE: Years Months Days It less than one day

Inf. 6 mo. 4 hrs. 20 min.9. Birthplace Easton Memorial Hospital

(Town, county, and state)

10. Usual occupation ch.

11. Industry or business

12. Name Mrs. Thane John Smullen13. Birthplace Salisbury, Md.14. Maiden name Miss Faretta Lewis15. Birthplace Easton, Md.

16. Informant

Address Mother17. (Burial, cremation, or removal, Which?) Aug. 8-1946 Date thereof PresumptionCemetery or crematory Memorial HospitalLocation Easton, Md.18. Funeral director Memorial HospitalAddress Easton, Md.19. 8/8 16 N.B. Neuman

Address

20. 8/8 16 N.B. Neuman

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1946 at 2:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 8 1946 to August 8 1946and that I last saw him alive on August 8 1946

Immediate cause of death

Prematurity

DURATION

3 hoursDue to unknown

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. T. B. Ambler M. D. or otherAddress Easton, Md. Date signed 8-8-46

120 14¹³
14⁰⁵
2

RECEIVED
AUG 10 1946
BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B.P.

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: Talbot
 County.....
 City or town near Matthews Town
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Talbot
 City or town near Matthews Town
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Annie E. Swann3. (b) Social Security Number
None

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Clarence H. Swann
 6. (c) If alive, give age 64 years
 7. Birth date of deceased (mo., day, yr.) May 29 1877
 8. AGE: Years 69 Months 2 Days 2 If less than one day
hrs.min.

9. Birthplace Easton, Talbot Co. Maryland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 FATHER 12. Name Daniel H. Cox
 13. Birthplace Preston Caroline Co. Md.
 MOTHER 14. Maiden name Clara Cox
 15. Birthplace Easton Talbot Co. Md.

16. Informant Clarence H. Swann
 Address Matthewstown

17. Burial Date thereof 8-3-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Springhill
Easton Maryland
 Location
 18. Funeral director J. Norman Marshall
 Address St. Michaels, Maryland
 19. 8/3 19 46 N.H. Neuring
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1946 at 11 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24 1944 to August 1 1946
 and that I last saw him alive on August 1 1946
 Immediate cause of death Chronic Endo-
carditis, valvular
disease
 Due to.....
 Due to.....
 Other conditions Chronic arthritis
 (Include pregnancy within 3 months of death)

DURATION

several
years

Major findings of operations.....
 Date of op.
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?.....
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE Kurt Lederer M.D.
 Address Green Lane Md M. D. or other
 Date signed 8/3/46

RECEIVED

AUG 10 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 08353 290

1. PLACE OF DEATH:

County Edm.
 City or town Edm.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 19 yrs.
 Hospital, Institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ms. County Edm.
 City or town Edm.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Elvino D. Tripp

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced M.
 6.(b) Name of husband or wife Edna Riker Tripp
 6.(c) If alive, give age 61 years
 7. Birth date of deceased (mo., day, yr.) July 8, 1883
 8. AGE: Years 63 Months 2 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Todd County, Iowa
 (Town, county, and state)

10. Usual occupation Palmer

11. Industry or business

12. Name Edmund R. Tripp
 13. Birthplace Ms.
 14. Maiden name Melissa E. Schwartz
 15. Birthplace Ms.

16. Informant Mrs. J. Ramsey Allen Jr.
 Address Royal Oak, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof August 16, 1946
 (month) (day) (year)
 Cemetery or crematory Spring Hill
 Location Edm. Maryland

18. Funeral director R. E. E. E. E.
 Address Edm. Ms.

19. 8/15 19 46 N. H. Nevins
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 19 46 at 3:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____
 and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Bronchopneumonia
Metastatic Carcinoma

Due to _____
 Due to _____

Other conditions Adenocarcinoma
of Colon
 (Include pregnancy within 3 months of death) 6 months

Major findings of operations Carcinomatosis of
abd. cavity Date of op. 6-29-46

Autopsy results not done
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE J. T. B. Ambler M. D. or other
Edm. Md. Address _____ Date signed 8-16-46

RECEIVED
AUG 24 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

08354

Reg. Dist. No. 294

1. PLACE OF DEATH:

County.....Talbot
 City or town.....McDaniel, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....34 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Talbot
 City or town.....McDaniel,
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Henry Clay Tunis

3. (b) Social Security Number

None

4. Sex male	5. Color or race white	6. (a) Single, married, widowed, or divorced widower
----------------	---------------------------	---

6. (b) Name of husband or wife.....Viola White Tunis
 8. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) Nov 1, 1854
 8. AGE: 91 Years 9 Months 4 Days
 It less than one day
 _____ hrs. _____ min.

9. Birthplace.....St. Michaels, Talbot Co., Md.
 (Town, county, and state)

10. Usual occupation.....Lumberman

11. Industry or business.....

12. Name.....John H. Tunis

13. Birthplace.....Penna.

14. Maiden name.....Georgiana Lowe

15. Birthplace.....Talbot Co., Md

16. Informant.....Mrs. Earle Kemp

Address.....McDaniel, Maryland.

17. Burial Date thereof Aug 6 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Lorraine Cemetery

Location.....Baltimore, Md.

18. Funeral director.....Newman & Harrison

Address.....St Michaels, Md.

19. Aug. 5th 1946 Anna C. Thomas
 (Date reg'd by registrar) Rep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Aug. 4th 1946 at 2 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 6 1946 to Aug. 4 1946
 and that I last saw him alive on Aug. 3rd 1946

Immediate cause of death.....Paralysis - cerebral hemorrhage (left)
 DURATION about 1 mo.

Due to.....Arterial sclerosis Serials

Due to.....Smoking gross

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE.....J. Stofel MD

Address.....St Michaels, Md. Date signed Aug 4th 1946

CENTERS FOR DISEASE CONTROL AND PREVENTION

REPORT OF DEATH

NAME

AGE

DATE OF DEATH

PLACE OF DEATH

SEX

CAUSE OF DEATH

DATE OF REPORT

REPORTER

ADDRESS

CITY

STATE

COUNTY

RECEIVED
AUG 20 1966
BUREAU V S

2 AM Aug 18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-6)

CERTIFICATE OF DEATH

08355

Reg. Dist. No. 291

1. PLACE OF DEATH:

County Talbot
 City or town Newcomb Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Newcomb Md
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot
 City or town Newcomb
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Kate H. Walling

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife David Walling
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 1883
 8. AGE: Years 63 Months _____ Days _____ If less than one day _____ hrs. _____ min.
 9. Birthplace Ireland
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 12. Name Hall
 13. Birthplace Ireland
 14. Maiden name Unknown
 15. Birthplace _____

16. Informant Catherine Walling
 Address Newcomb Md.
 17. Burial Date thereof Aug. 14, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mt. Olivet
 Location St. Michaels, Md.
 18. Funeral director J. Norman Marshall
 Address St. Michaels, Md.
 19. Aug 14 19 46 John Stowal
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12th 1946, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29th 1946, to Aug 12th 1946, and that I last saw him alive on Aug 11th 1946.

Immediate cause of death Endocarditis
(mythical reorganization)

DURATION

Do not know

Due to _____

Due to _____

Other conditions Chronic nephritis Do not know

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE S. Henry Williams M.D. M. D. or otherAddress St. Michaels, Md. Date signed Aug 13, 46

RECEIVED
AUG 19 1946
BUREAU V.8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for change of age MARYLAND STATE DEPARTMENT OF HEALTH
of deceased is shown on

2411 N. Charles St., Baltimore 1220

FILM No. I 07 OCT 8 1946

CERTIFICATE OF DEATH

Reg. Dist. No. 08356 290

1. PLACE OF DEATH:
County... Talbot
City or town... Boston, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
The Memorial Hospital.
How long in hospital or institution? 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Maryland County... Caroline.
City or town... Pidgeley
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION) ✓
2. (a) If veteran, name war _____

3. (a) FULL NAME
Mr. Harry Wilson.

3. (b) Social Security Number

4. Sex M 5. Color or race W. 6. (a) Single, married, widowed, or divorced _____

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) July 2, 1880 6. (c) If alive, give age _____ years

8. AGE: Years 65 Months 66 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace... Caroline Co. Maryland
(Town, county, and state)

10. Usual occupation... Farmer

11. Industry or business... Flower mill

12. Name... Mr. J. D. Wilson

13. Birthplace... Caroline Co. Md.

14. Maiden name... Mary Sullivan

15. Birthplace... Caroline Co. Md.

16. Informant... Harry Wilson

Address... Pidgeley, Md.

17. Burial, cremation, or removal. Which? Buried Date thereof 9-5-46
(month) (day) (year)

Cemetery or crematory... Pidgeley Cemetery

Location... Pidgeley, Md.

18. Funeral director... J. Edgar Wilson & Son

Address... Pidgeley, Md.

19. 9/2 19 46 N. H. Neenan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 8/31/46 19... at 7:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 22 19 46 to 8/31 19 46

and that I last saw him alive on 8/31/46 19 46

Immediate cause of death... Acute Myocardial

failure

Due to... Myocardia

Due to... Suppurative pneumonia

Other conditions... left

(Include pregnancy within 8 months of death)

Major findings of operations... None

Autopsy results... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE... George White M.D.

M. D. or other _____

Address... Pidgeley, Md. Date signed 9/3/46

RECEIVED
SEP 7 1946
BUREAU V.E.

1720

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of
year of birth is shown on
G107 9/13/46 PRC

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County Talbot

City or town Cordova Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Wesley Wilson

4. Sex

male

5. Color or race

C

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Jennett Wilson

7. Birth date of

deceased (mo., day, yr.)

Dec 24 1905 1904

6. (c) If alive, give age years

8. AGE:

Years

41

Months

8

Days

3

If less than one day

hrs. min.

9. Birthplace

Talbot County Md.
(Town, county, and state)

10. Usual occupation

Salver

11. Industry or business

FATHER

12. Name

Winnett Sams

13. Birthplace

Talbot County Md.

14. Maiden name

Thomas Wilson

15. Birthplace

Cordova Talbot Co. Md.

16. Informant

Jennett Wilson

Address

Cordova, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Aug 29 1946

Cemetery or crematory

New Chapel Cemetery

Location

Easton Md. Talbot Co.

18. Funeral director

Carl W. Stafford

Address

Easton Md.

19.

(Date rec'd by registrar)

19

46

J. L. Newman

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Talbot

City or town

Cordova
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

213-18-5631

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 27 1946 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1945 to August 1946

and that I last saw him alive on March 15 1945

Immediate cause of death

Coronary Thrombosis

Duration

sudden

Due to

Coronary disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert Pedersen M.D.

M. D. or other

Address

Queen Anne Md.

Date signed 8/27

SEP 4 1946

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SEP 4 1946

BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 882

CERTIFICATE OF DEATH

Reg. Dist. No.

08358

290

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

7. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.).....

6. (c) If alive, give age..... years

8. AGE:

Years.....

Months.....

Days.....

If less than one day

57 about

..... hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial

(Burial, cremation, or removal. Which?).....

Date thereof.....

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. 8/27

(Date rec'd by registrar)

19 46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Aug 26 1946, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1 1946, to Aug 26 1946

and that I last saw him alive on

Aug 23 1946

Immediate cause of death.....

DURATION

Cerebral hemorrhage

4 days

Due to.....

Arteriosclerosis

several years

Due to.....

Other conditions.....

no

(Include pregnancy within 3 months of death)

Major findings of operations.....

no

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

no

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

A. M. C. Stevens M.D.
Easton Md
Date signed 8-26-46

RECEIVED
SEP 4 1946
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 984

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH:

County Talbot
City or town St Michaels Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: _____

Stay in hospital or Inst. (yrs., or mos., or days) _____

Stay in this community (yrs., or mos., or days) 18 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County city
City or town Baltimore Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)

Street No. _____
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Eliza Brooks Wood

3. (b) Social Security Number

4. Sex 7 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John Wood

6(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 6, 1883

8. AGE: Years 63 Months 3 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace St. Michaels Talbot Md.
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

12. Name Alex. Brooks

13. Birthplace Talbot Co

14. Maiden name Mar. Grace

15. Birthplace Talbot Co

16. Informant Geo. Brooks

Address St. Michaels

17. Burial Date thereof 8-14-46
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Sherwood Md.

Location Sherwood Md.

18. Funeral director Leon St. Henry

Address 114 Port St.

19. Aug 13 19 46 John H. H. H. H.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 19 46, at 3:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26 19 46, to Aug 12 19 46, and that I last saw her alive on Aug 12 19 46.

Immediate cause of death Chronic Myocarditis DURATION 1 year

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work? _____

23. SIGNATURE Hayward T. Pratt M.D. M. D. or other _____

Address Edison, Md. Date signed 8/12/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

CERTIFICATE OF DEATH

RECEIVED
AUG 19 1946
BUREAU V 8